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First Look at the 2003 Youth Risk Behavior Survey: Obesity and Our Youth (First in a Series)

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The Centers For Disease Control and Prevention (CDC) introduced the Youth Risk Behavior Survey (YRBS) in 1990. According to the CDC, the survey was designed to 1) determine the prevalence of health risk behaviors; 2) assess whether health risk behaviors increase, decrease, or stay the same over time; 3) examine the co-occurrence of health risk behaviors; 4) provide comparable national, state, and local data; 5) provide comparable data among subpopulations of youth; and 6) monitor progress toward achieving the Healthy People 2010 objectives and other program indicators.[1] The YRBS covers several topical areas including: intentional and unintentional injuries, suicide, tobacco/alcohol/drug use, sexual behaviors, weight and dietary behaviors, physical activity, and HIV education. The Metro Public Health Department (MPHD) has administered the survey every two years since 1999. MPHD utilizes the 87-question survey and administration protocol developed by the CDC.

This year, 15 public and 5 private schools participated in the survey yielding a sample of 1,884 students. The demographic profile of students participating in the 2003 survey were: 53% female and 47% male; 48% white, 42% black or African-American, 7% other race or ethnic group, and 3% multi-racial; 29%were in ninth grade, 23% in tenth grade, 30% in eleventh grade, and 18% in twelfth grade.

In This Issue:

Table 1. Demographic Profile of 2003 YRBS Survey Respondents

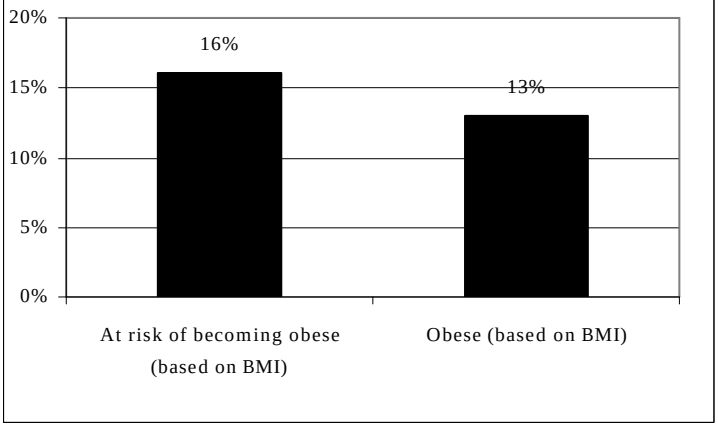
Sex	
Female	53%
Male	47%
Race	
Black/African American	42%
White	48%
Other Race/ethnicity	7%
Multi-racial	3%
Grade Level	
9th	29%
10th	23%
11th	30%
12th	18%

While data are collected on a variety of risk behaviors, obesity can be seen as a "gateway disease/disorder"(much like marijuana is referred to as a gateway drug) that plagues a significant number of our youth. Obesity can be identified in this manner because it has been identified as a contributing factor for many chronic diseases and conditions. These diseases and conditions include: type-2 diabetes, hypertension, heart disease, stroke, breast cancer, colon cancer, gall bladder disease, and arthritis.[2]

In 2003, the results of the YRBS here in Nashville and Davidson County revealed that a stunning 13% of our youth are obese and an additional 16% are at risk of becoming obese (based on body mass index). (See Figure 1 on page 2.) The number of youth who are obese in Nashville (13%) is far above the Healthy People 2010 goal of 5%. The percentage of Nashville youth who are obese has remained stagnant since

continued on page two

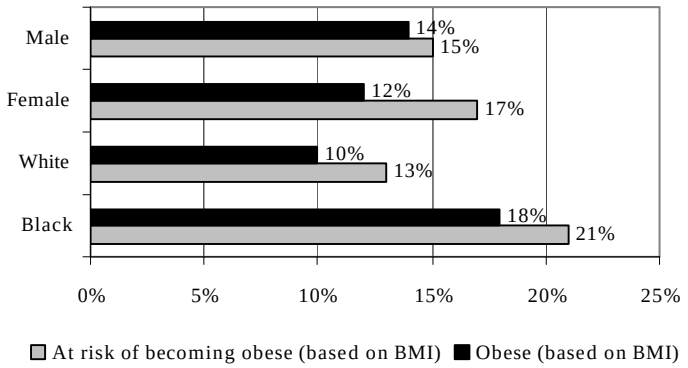
Figure 1. 2003 Nashville YRBS Weight Status Results



2001. Across the state in 2003, an alarming 15.2% of youth are obese, with an additional 14.8% being at risk.

Not only are these statistics staggering overall, but disparities also exist. In terms of sex differences, males (14%) are more likely than females (12%) to be obese. On the other hand, female (17%) students were more likely to be at risk for becoming obese than their male (15%) counterparts. The disparities seen among obese youth are even more apparent between black and white students. Black students were nearly twice as likely to be obese than white students. A similar trend was apparent among those who are at risk of becoming obese, with black students being more likely than their white counterparts. (See Figure 2 below.)

Figure 2. Youth Who Are at Risk for Becoming or Already Are Obese



These statistics reveal that the fight to combat obesity begins well before reaching adulthood. Our youth are in grave danger of not only being/becoming obese but also developing health issues that typically afflict adults. Currently there are several federal initiatives aimed at helping individuals become healthier. The most recent initiative, *Steps to a Healthier US*, awards federal grants to communities across the nation to help address diabetes, asthma, and obesity.[3] At the local level, Mayor Purcell has been instrumental in supporting a variety of Metro Parks and Recreation improvement plans. These plans include improving existing parks and playgrounds and the development of new parks, greenways, and athletic activities among others[4]. These initiatives mark an important first step in helping our youth become more active and combating the dangers associated with obesity.

References:

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Hepatitis C in Davidson County

Ingrid K. Renberg, B.S., B.A., Student Intern

If someone were to ask you, "What is hepatitis C?" would you be able to answer? Recent studies have shown that while hepatitis C virus (HCV) is the most common bloodborne infection in the U.S. hardly anyone has a concrete definition of what it is, how it is transmitted, who is at risk, or possible prevention methods.

HCV is a virus of the *Flaviviridae* family, which also encompasses the other five hepatitis viruses (A, B, D, E, and G). HCV is difficult to diagnose in that during the early phase of infection the virus appears inactive so onset of infection may go undetected. Because it is "hidden" in the body, a person can easily transmit HCV to a number of people before a diagnosis is made. They in turn can infect more people, and in a short time, HCV can be transmitted to several people before symptoms appear in the first case.[1]

The severity of HCV varies from person to person. Eighty-five percent of HCV patients have chronic HCV, meaning they will have it for more than six months.[1] Once a person has chronic HCV, the virus is almost never eradicated from the body. The complications of HCV can be as minimal as slight liver disease or as severe as cirrhosis, liver failure, and primary liver cancer. Cirrhosis attributed to HCV is currently the leading indication for orthotopic liver transplant.[2]

The Centers for Disease Control and Prevention (CDC) has set two goals of HCV prevention: 1) reduce incidence of new infections by reducing HCV transmission and 2) reduce the risk of chronic liver disease in HCV-infected persons through appropriate medical management and counseling.[3] Since HCV may go undiagnosed for up to ten years, it can be difficult to identify a source of transmission. If transmission between individuals can be stopped, however, then the incidence of liver disease in the overall population will be significantly impacted.

HCV mutates frequently (like the virus that causes HIV infection) making the quest for a vaccination difficult.[4] Presently, however, there are a few possibilities to combat the virus. Two antivirals, interferon alpha-2b and ribavirin, have been shown to decrease the progression of the disease. There is also testing going on concerning protease and helicase inhibitors which could disrupt the enzymatic processes of the virus and block replication. [4]

HCV is of special concern to healthcare personnel and drug users. It is estimated that 300 healthcare personnel will die annually from HCV exposure that occurred on the job. Risks such as puncture wounds or handling infected blood are concerns for nurses and physicians. Drug users are often infected with HCV by using infected needles. Programs initiated to educate about the risks of sharing needles have significantly decreased the number of people acquiring HCV from drug abuse; however, this means risk of exposure remains a concern.[5,6,7]

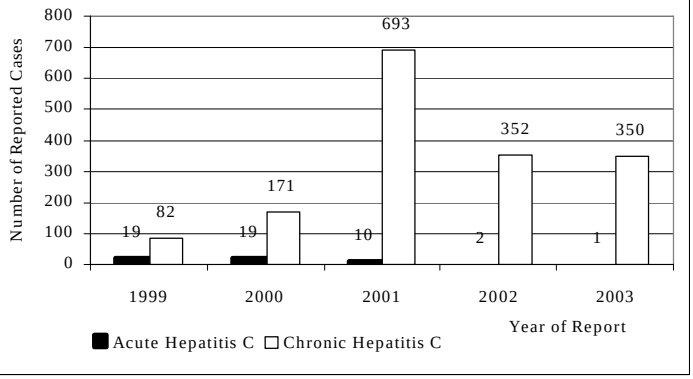
Several other factors contribute to the spread of HCV. Blood transfusions, organ transplantation, sexual contact, non-sexual contact involving exposure to blood, perinatal transmission, body piercing, and tattooing have all been linked to the spread of HCV.[8]

Metro Public Health Department (MPHD) has been monitoring chronic HCV cases in Davidson County since 1999. (See Figure 1.) There was a significant increase in the number of HCV-infected people reported to MPHD through 2001. However, in 2002, there was a slight decrease in the number of reported cases. The number of HCV cases reported this year to date is 350, which is almost equals last year's total of 352.

MPHD continually works to achieve the HCV prevention goals outlined by the CDC. Pat Sanders, HCV Coordinator at MPHD, provides telephone counseling for each person diagnosed with the disease. After counseling, an HCV-infected person can be vaccinated for hepatitis A and hepatitis B in an effort to limit liver damage from these diseases. If an infected individual is uninsured, they are directed to Bridges

continued on page four

Figure 1. Reported Cases of Hepatitis C, 1999 - 2003, Nashville, Tennessee



to Care, a program designed to link uninsured persons with a medical provider. MPHD staff also work to educate people regarding HCV before infection occurs by providing HCV educational seminars in the community. Pat Sanders believes that the best prevention method would be to educate children in schools as they are being educated about HIV or other STDs.[9] Hopefully, as the word about HCV is spread, there will be more people knowledgeable about transmission methods associated with this disease as well as ways to protect themselves.

For more information about Hepatitis C, contact Pat Sanders at 615-340-5632.

References:

[1]Younossi, Z. 1997. Chronic hepatitis C: a clinical overview. *Cleveland Clinic Journal of Medicine*, 64, 259-267.
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[5]Neff, G., Shciff, E. 1999. Chronic hepatitis C: populations at risk and treatment strategies. *Hospital Medicine*, 12.
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[7]Buffington, J. et al. Racial differences in knowledge regarding hepatitis C virus infection. 2000. *JAMA*, 284, 1651-1652.
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[9]Personal communication on December 3, 2003.

Hot Topics
Caring for Children with Special Health Care Needs

Patricia Khalil, Program Supervisor, Children's Special Services (CSS)

The second annual conference sponsored by Children's Special Services (CSS) entitled "Hot Topics: Caring for Children with Special Health Care Needs" was held on Monday, October 27, 2003 at Nashville's Downtown Public Library. This year's conference boasted over 120 in attendance, being a blend of service providers as well as parents and foster parents. Attendees came from as far away as Chattanooga, Dickson, Columbia, Cookeville, and Jackson, Tennessee.

This year's conference was held coincidentally during the showing of artist Laura Craig McNellis' "Inside Out 1970 – 2003" exhibit. She is a member of the Riddle Institute's Studio XI/Signature Home for artists who have developmental disabilities. Ms. McNellis is a self-taught artist whose works can be found in private collections and museums internationally. During the lunch break, conference attendees were given the opportunity to view Ms. McNellis' exhibit as well as over 20 program/agency booths filled with resource information to better serve families and children with special health care needs of all kinds.

The day began with a welcome by Dr. Kimberlee Wyche-Etheridge, M.D., MPH, the Child and Adolescent Health Division Director for Metro Public Health Department. Next, Dr. Ellen Wright Clayton, the Rosalind E. Franklin Professor, Director of the Center for Genetics and Health Policy, Practicing Doctor of Pediatrics and Professor of Law, presented an informative keynote on the use of genetics in today's medical world. Dr. Clayton offered an array of information that was both practical and applicable for all children's programs, in order to better serve families through early genetic identification, thus enabling early and appropriate interventions. Mark Huffman, Vice President of Education and Tamara Currin, Educator and Trainer of Planned Parenthood of Tennessee gave an inclusive and helpful presentation regarding sexuality issues for children of all abilities. Kappu Deshpande, RN, MSN, ENT-P, the District Chief of Emergency Medical Services for the Nashville Fire Department, shared information imperative to all caregivers of anyone with special medical needs and how to best assist emergency medical personnel toward the most appropriate care during an emergency situation.

The first part of the afternoon offered a choice between two sets of breakout sessions. The first set of concurrent sessions included two options. The first was entitled "Recreational

continued on page five

Keynote speaker, Dr. Ellen Wright Clayton, M.D., J.D., discusses the most recent issues related to Families and Genetics in America.

Joan Jenkins from Special Olympics addresses a group of caregivers and professionals on Recreational Ideas for Children with Special Health Care

Ideas for Special Needs Children" and was presented by Rick Slaughter, Director of the Wheelchair Basketball Youth Program; Blaine Smith, coordinator of the Wheelchair Tennis Program; and Joan Jenkins, Vice President of Marketing and Development for Special Olympics of Tennessee. The second option was entitled "Multicultural Educational Issues" and was presented by a panel of professionals including Cathy Anderson, Social Worker for Metro Social Services Refugee Program; Sadot Azzua, Hispanic Outreach Coordinator for Outlook Nashville; Deborah Diaz, Care Coordinator for Tennessee Early Intervention Services; Carol Garrett, Coordinator of Special Education for Metro/Nashville Public Schools; Colleeen Gibson, Coordinator of the Nashville Family Alliance Center; and Carolyn Logsdon, Coordinator for Tennessee Infant Parents Services. The second set of concurrent breakout sessions also included two options. The first was entitled, "Bioterrorism and Disaster Planning" and was presented by Sheila McCloskey, RNC, Director of Children's Special Services (CSS) Davidson County and Cherry Entrikin, RN, Emergency Response Nurse/ Hospital Liaison for the Notifiable Disease/Bioterrorism Division of the Metro Public Health Department, Nashville, Tennessee. The second option was entitled, "Early Detection of Mental Health Issues" and was presented by Dr. Matt Timm, PhD, Co-Principal Investigator for the Early Childhood Intervention Study and Director and consultant to the child Care Consulting Program at Tennessee Voices for children and Mamie McKenzie, Coordinator of the Child Care Consulting Program at Tennessee Voices for Children.

The last segment of the day involved a compassionate and motivational presentation entitled, "Love Is the Key" presented by Eric Johnston, Director of Prevention Services for STARS program.

continued on page six

Hot Topics: Caring for Children with Special Health Care Needs...continued from page five

Throughout this year's planning process, the CSS staff was both impressed and appreciative of the combined efforts of strong support from the Steering Committee that included persons from several children's programs as well as parents and parent input. Plans have already begun toward next year's conference, focusing on continued partnerships and offerings to address the Hot Topics that lie ahead for the coming year. If you would like to be a part of the Steering Committee for 2004 or just have suggestions toward program planning, please contact Sheila McCloskey at 615-340-0564. With continued community partnerships and the sharing of resources, we look forward to providing up to date information to ensure that families of children with special health care needs are given access to the best possible base of information from which to make important decisions.

Blaine Smith, Tennis Director at Metro Sportsplex, and Rick Slaughter, Director of ABLE Youth (a wheelchair sports program for kids), addresses a crowd of caregivers and professionals in a session on Recreational Ideas for Children with Special Health Care Needs.

Influenza Update

The following information was obtained from the Centers from Disease Control and Prevention website at: http://www.cdc.gov/flu. The information applies to the week ending December 6, 2003.

- Influenza activity in the United States continued to increase during the week.
- For the week, 5.1% of patient visits to sentinel providers were for influenza-like-illness. The national baseline is 2.5%.
- The percentage of visits for influenza-like-illness was highest in the Pacific and Mountain regions followed by the South Central region (Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, and Texas).
- Influenza activity was reported as widespread in 24 states: Alaska, Arizona, Arkansas, Colorado, Idaho, Indiana, Iowa, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming. Only 5 states reported sporadic influenza activity: Delaware, Hawaii, Maine, New Hampshire, and Wisconsin.
- During the week, 7.0% of all deaths reported by the vital statistics offices of 122 U.S. cities were due to pneumonia and influenza.
- So far in this influenza season, the influenza A/ Fujian/411/2002-like viruses are predominating in the United States. This strain differs from the influenza A (H3N2) virus contained in the 2003— 04 vaccine (i.e., A/Panama/2007/99). The A/Fujian-like viruses are antigenic drift variants of the A/Panama strain and were detected by global surveillance early this year but too late for inclusion in the current influenza vaccine.
- Approximately 83.4 million doses of influenza vaccine were produced for the 2003— 04 influenza season. This includes the inactivated influenza vaccine as well as the Live Attenuated Influenza Vaccine. According to the CDC, all doses of the inactivated vaccine appear to have been sold by the manufacturers and their distributors.

continued on page seven

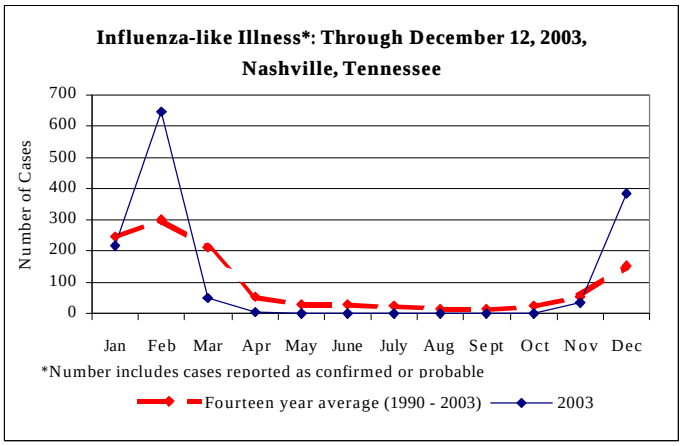
influenza Update ...continued from page six

As of December 10, 2003, the World Health Organization's (WHO) website at http://www.who.int/en/ provided the following information pertaining to influenza.

- Significant increases in influenza activity associated with influenza A viruses continues in the European countries of Finland, France, Norway, Portugal, and Spain.
- Influenza activity was first noticed in some parts of Canada and in the United Kingdom this year. The number of cases has started to decline in these countries but WHO feels that it is too early to view this decline as a trend.
- Although influenza activity is low, an increase in cases is noted in the Czech Republic, Denmark, Italy, Latvia, the Russian Federation, and Switzerland.
- Influenza B viruses are most frequently reported from Asia (Hong Kong, Republic of Korea, and Thailand) although sporadic cases have been reported in Europe and North America.
- Most influenza outbreaks have been caused by influenza A (H3N2) viruses and confirmed to be either A/Fujian/411/2002-like or A/Panama/2007/99-like.
- No influenza activity was reported in Croatia, Iceland, Japan, or Poland.

Season's Greetings from Public Health Watch

In Nashville, 467 cases of influenza have been reported to Metro Public Health Department in November and December 2003.



Reported Cases of Selected Notifiable Diseases for September/October 2003

Disease	Cases Reported in September/October		Cumulative Cases Reported through October	
	2002	2003	2002	2003
AIDS	50	53	202	234
Campylobacteriosis	6	0	31	17
Chlamydia	396	447	1,786	2,450
DRSP (Invasive drug-resistant *Streptococcus pneumoniae*	0	1	18	21
Escherichia coli 0157:H7	0	0	5	0
Giardiasis	6	0	33	18
Gonorrhea	301	214	1,171	1,353
Hepatitis A	3	1	17	8
Hepatitis B (acute)	0	1	17	18
Hepatitis B (perinatal)	2	2	24	24
HIV	73	58	280	267
Influenza-like Illness	2	0	225	918
Neisseria meningitidis disease	2	0	5	0
Salmonellosis	6	1	52	41
Shigellosis	2	0	10	10
Syphilis (primary and secondary)	1	5	24	22
Tuberculosis	9	7	57	47
VRE (Vancomycin-resistant enterococci)	5	0	50	38

To report a notifiable disease, please contact:

Sexually transmitted diseases: Brad Beasley at 340-5676
AIDS/HIV: Mary Angel-Beckner at 340-5330
Hepatitis B: Denise Stratz at 340-2174
Tuberculosis: Alisa Haushalter at 340-5650
Hepatitis C: Pat Sanders at 340-5632
Vaccine-preventable diseases: Mary Fowler at 340-2168
All other notifiable diseases: Pam Trotter at 340-5632

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